

DOCUMENT RESUME

ED 231 545

PS 013 765

AUTHOR Amidei, Nancy
TITLE Poor Children and American Social Policy: Are We Meeting Our Responsibilities?
INSTITUTION Food Research and Action Center, Washington, D.C.
PUB DATE Jun 83
NOTE 29p.; Paper presented at the Bush Program in Child Development and Social Policy (Ann Arbor, MI, June 17, 1983).
PUB TYPE Viewpoints (120) -- Speeches/Conference Papers (150)
EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Child Welfare; Data Collection; Diseases; *Family Programs; *Financial Support; High Risk Persons; Hunger; Low Income Groups; *Poverty; *Public Policy; *Social Problems; Social Responsibility; *Social Services; Unemployment
IDENTIFIERS Reagan Administration

ABSTRACT

As a result of budget cuts and policy changes, health, nutrition, and social welfare programs have been rendered less able to help children and families, particularly those families hard hit by the recession. It is argued that there is no excuse for these cuts and that if the economy were growing and employment levels were high, the budget cuts might have made some sense. However, the context in which policy choices are being made can be summed up in three points: poverty is increasing, eligibility for assistance is decreasing, and those who qualify for assistance get less. Sophisticated national data on these problems are increasingly unavailable and less likely to be promptly analyzed or published than in the past. Personal and anecdotal reports do indicate that severe problems exist; for example: soup kitchens, inadequate medical coverage, inadequate prenatal care, temporary foster care placements, itinerant families, infants of low birth weight, infant death, children who fail to thrive, the effects of toxic water on infants, and prolonged poor nutrition among the elderly. Further, presently available data provide evidence that hunger and malnutrition are serious problems once again. These data come from six sources: the numerous individuals below the poverty line, reports from private and public agencies, media reports, local studies, and medical reports. Finally, these shifts in public policy will have important long-term implications. (RH)

* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION
CENTER (ERIC)

X This document has been reproduced as
received from the person or organization
originating it.

Minor changes have been made to improve
reproduction quality.

• Points of view or opinions stated in this docu-
ment do not necessarily represent official NIE
position or policy.

ED231545

Poor Children and American Social Policy:

Are we meeting our responsibilities?

by

Nancy Amidei

PS 013765

Prepared for the Bush Program
in Child Development and Social Policy
University of Michigan
Ann Arbor, Michigan
June 17, 1983

"PERMISSION TO REPRODUCE THIS
MATERIAL HAS BEEN GRANTED BY

Nancy Amidei

TO THE EDUCATIONAL RESOURCES
INFORMATION CENTER (ERIC)."

I want to use my time with you to do three things: first, take you through some of what I have been learning in my personal odyssey into the consequences of the past two years' budget cuts; second, describe key elements of the context in which those consequences are being noted; and finally, comment briefly on some recent shifts in public policies affecting low-income families. Because most of my time is spent on the issue of hunger, relatively more of my examples will be drawn from that area, but families poor and troubled enough to be hungry tend to be facing other problems as well.

This involves covering a lot of territory in a short period of time, and is a bit unorthodox in being more personal and more anecdotal than scientific, but I hope you will bear with me. I am so conscious of the devastating consequences of recent policy changes for vulnerable families all across the country that I feel some responsibility to report on their circumstances, to speak for them in whatever forum becomes available to me. I understand the limitations in "data" as personal as this. But I am also conscious of the reasons why there is not more or better information available, and hopeful that accounts such as mine will help stimulate the kind of careful, systematic reviews that policy-makers will require in the months to come.

You may sense some impatience in what I have to say; it is real, it grows daily. I have now been in too many soup kitchens, emergency food pantries, food banks, food lines, social service agencies and crisis centers of all kinds not be impatient. Soup kitchens should have no place in modern America, voluntary temporary foster care placements should not be the only alternative for the children of recession victims in 1983. We know enough to prevent much of what is happening, and we are still a wealthy enough nation to make that knowledge and help available. There is simply no excuse for the fact that hunger and malnutrition, T.B. and homelessness, and a host of poverty and stress related problems are serious or growing problems once again.

I have a second, equally personal reason for feeling impatient. Just this week I attended a gathering on the tenth anniversary of the death of Dr. George Wiley, the charismatic leader of the National Welfare Rights Organization. Welfare rights activists from all across the country came back together, to remember George, and to let his children know how important he was to so many people.

The evening left me feeling buoyed up by the presence of so many people who care about poor children and their families, and who have continued to struggle -- in a variety of ways -- on their behalf. But I was also terribly discouraged as the memories came flooding back, and I realized how far we have yet to go, how much ground we've lost, how many of the old fights need to be re-fought, and won, again. Low-income women and their children still cannot be assured of basic rights, basic respect, or even minimal levels of assistance in times of crisis. That we should be at such a point twenty years after the welfare rights movement was born, should leave every caring American sad.

CONSEQUENCES

When the first round of recent budget cuts was adopted in 1981, most members of Congress sincerely hoped that the economy would indeed improve dramatically and that no one would suffer adverse consequences from their actions. That may have been naive, but it was genuine. Most members of Congress, as most members of the public, did not make a deliberate choice in favor of pain and human suffering for millions of American children and their families. They made a choice in favor of change, and hoped the change would be positive.

By now we and they know otherwise. The economy has not improved in ways that would ease the rate of unemployment or the plight of the unemployed, and there is growing evidence that the policy choices of the past two years have serious adverse consequences.

The litany of those consequences grows daily...in numbers, in kinds and degrees of severity. First, the consequences in programmatic terms, with their

implications for the future capability of publicly supported systems to help children and families can be briefly told, and then the consequences which are measured in more human terms.

Impact on Programs

Health, nutrition, and social welfare programs have been rendered less able to help children and families -- particularly those families hard hit by the recession -- as this brief look at the budget choices made since 1981 reveals.

In 1981 \$40 billion was cut from the federal budget. Roughly 70% of those "savings" came from programs that the unemployed and other poor people depend on. Child nutrition programs were slashed by one-third, the food stamp program was cut by \$2 billion the first year (\$11 billion over three years), AFDC and Medicaid lost nearly \$3 billion. Jobs, training, and unemployment insurance lost \$5.5 billion; commitments to repair or produce desperately needed low-cost housing were cancelled. Overall, the operating budget of virtually every health and social welfare program important to low-income families was reduced--by 20%, 30% or more.

Each of the budget reductions was accompanied by policy changes. Fewer children are eligible for free or low-priced meals; women trying to work their way off welfare no longer get AFDC or, more important, Medicaid coverage for their children; rents in subsidized housing went up; school districts in poor neighborhoods lost funds; day care and other social services lost 20-30% of their operating base.

Then, in 1982, programs serving vulnerable children and families were hit by more budget cuts and policy changes. The President wanted programs serving poor people cut by another 44%, through block grants, lower income eligibility limits, and the elimination of more basic services. Congress rejected many of those proposals, and cut considerably less in dollar terms than the year before, but the effect was still devastating because the recession had deepened, the effect of cuts is cumulative, and more people were poor.

In 1983, the President called for still more budget cuts in social programs, but Congress thus far has not agreed -- though neither has it moved to undo the damage of earlier years.

These large budget numbers translate into specifics as day by day health and social welfare agencies struggle to meet growing needs with smaller staff, smaller budgets, and ever more complex regulations. A few examples illustrate the point.

-- Following the federal budget cuts, every state has now made cuts in the services, coverage, and/or reimbursement for health care provided under state Medicaid plans; nationally there are now fewer physicians and hospitals willing to serve Medicaid patients. Because hard-hit state and local budgets cannot replace the lost federal dollars, entire services are being curtailed, as in the city of Birmingham, Alabama where all hospital emergency rooms but one now close on weekends. In Los Angeles County, California, public clinics have been turning away patients, as are hospitals in San Francisco which served primarily Medicaid patients in the past.

-- Health Departments have had to absorb drastic reductions in personnel, with very sobering results. Staff reductions in Michigan and Ohio were part of the reason that last year each turned back over \$1 million in WIC program funds to the federal government. The clinics simply could not process the applicants. That is happening this year in hard-pressed states across the country as funds included in the Emergency Jobs Bill as a way to reduce some of the waiting lists for WIC are being sent back to Washington by critically under-staffed health department.

-- In Philadelphia the hospitals are asking for cash "up front" from women without health insurance. Those who cannot cover the costs of prenatal care and delivery are simply turned away; Medicaid no longer covers them and the hospitals feel they cannot absorb the loss.

-- Two-thirds of the fifty-five cities in a U.S. Conference of Mayors' survey responded that block grants had "adversely affected" services (health care services were among the most severely affected).

-- At a recent meeting of state Directors of Child Welfare Services, one director noted that budget reductions had left him with a smaller staff -- and with fewer workers, has had to re-assign inexperienced staff to protective services and coun-

selling departments that are responsible for troubled families in need of help.

The problem proved a common one for these program administrators.

-- Another state Director noted that the fiscal sanctions attached to welfare and food stamp error rates had caused a drastic shift within remaining personnel, putting even the best, most senior counseling and child welfare service staff into the effort to forestall error rate sanctions, rather than into helping troubled families.

-- State and county food stamp administrators echo the comment of one administrator who believes the application process has become so skewed that it is nearly impossible to be a "good" eligibility worker without being a "bad" professional.

-- Despite tighter eligibility rules, Dade County (Florida)'s Food Stamp program has grown by 16,000 households in just one year, causing delays in processing the applications of hungry families. In Oregon, food stamp personnel stopped taking appointments, leaving desperately needy families without a way to apply for food stamps unless they stood long hours in line, day after day. Workers in the emergency food outlets on Long Island complain that processing delays at the local food stamp office often run six weeks or more -- leaving a gap they cannot begin to fill. One North Carolina county food stamp office had a three-month backlog of applications. (The law, incidentally is clear: hungry people have a right to apply the day they come to the office, desperate people have the right to expedited service, and everyone has the right to have their food stamp applications processed quickly.)

-- FRAC conducted a survey to learn the impact of reductions in the school lunch and breakfast program and discovered that 3.2 million fewer children were participating in the program. Nearly 40% of the children no longer getting lunch at school live in low-income households; moreover, the budget cuts had proved so devastating that 2700 schools no longer serve lunch at all -- even for the poorest children.

-- Day care centers that depend on the Child Care Food Program in order to feed the children of the working poor were hard-hit. Budget savings in that program were achieved by limiting children to just two meals and one small snack each day -- even when the children are in care for 10 hours or more.

The Social and Economic Context

Budget decisions are not made in a vacuum. The budget cuts might have made some sense if the economy were growing and employment high, if revenues from state and local taxes were expanding. But policy-makers know that poverty and unemployment are high and rising. The context in which the policy choices are being made can be summed up in three points.

Poverty is up. Between 1979 and 1980, poverty rose by 12.3%. Between 1980 and 1981, it rose another 7.5%, and the 1982 figures (due out in July) are expected to record yet another increase.

For some groups the situation is particularly serious. Among all American families the poverty rate is 11.2%, but among families headed by a woman it is 34.6%. If the woman heading a household is Hispanic or Black, the poverty rate jumps to 53%. If that woman has three or more children to support, the likelihood of poverty is 72%, 76%, even 90%. For the children in those families, those are not good odds. Overall, one American child in four lived in a household with very low income (below or just above the poverty line) in 1981.

Nearly 32 million people lived below the poverty line in 1981, producing a poverty rate not seen in this country since 1967. The poor were to be found disproportionately in minority and female-headed households, and they were disproportionately the very old and the very young.

Another 12 million Americans were in households with incomes just marginally above the poverty line, a group known euphemistically as the "near poor." Just as some groups in the population are over-represented among the poor, those same groups are also found clustered in the "near poor" group -- just barely on the edge of dire poverty. Forty-two percent of all Black families, 35% of all Hispanic families, were in poor or near-poor households in 1981. When the 1982 numbers are available, we know they will be even higher.

These poverty statistics are related to the continuing high rates of unemployment which have, not surprisingly, recorded higher-than-average rates among the

very young and very old, female and minority workers. And when workers lose their jobs, in most cases they also lose their health insurance. The Congressional Budget Office estimates that 11.5 million Americans lost health care coverage as a result of losing their jobs. People without jobs can rarely afford private health insurance and are more likely to need publicly-provided health care. So there are public policy implications that flow from the basic facts.

In any case, continuing high rates of unemployment and rising poverty rates among Americans of all ages are a function of the state of the economy.

Eligibility for help is down. But who gets help and what kind of help are the direct result of deliberate choices made by elected officials at all levels, as part of a process that is shaped in important ways by a President and his Administration. Whether unemployed people get medical care or food for their children during times of severe economic recession is a function of the political process -- which is to say that in a democracy, all of us are to some degree responsible for the outcome.

So it is particularly sobering to realize that at the same time that the official agencies of government were recording increases in poverty and unemployment, our elected President and representatives in the Congress and State Legislatures were taking steps to make fewer of those in crisis eligible for any form of federally-funded help.

Today, when the group at risk numbers more than 44 million people, fewer than 16 million people get any kind of federally-supported cash welfare (from Aid to Families with Dependent Children -- AFDC, Supplemental Security Income for the elderly and disabled -- SSI, or the "cash out" of food stamps in Puerto Rico). Twenty-nine states give no welfare and most give no Medicaid coverage to families with a father present -- no matter how poor or sick or desperately in need the children. About 1.5 million children lost AFDC (and most also lost their eligibility for Medicaid) as a result of budget cuts in 1981; about 900,000 people lost their eligibility for food stamps that same year. Food stamps (the largest program)

now serves only a little more than 22 million people. Overall, about 41% of the poor get no federally-supported benefits.

Most Americans assume that help is there for the asking, that in times of genuine need there is tax-supported help to be had. The reverse is now more usually true: most people in need get little or nothing from federally-funded programs.

Those who still get help, get less. Adding insult to injury, even those who still qualify for help now generally get less than was true a few years ago -- despite the fact that food, utility, medical care and shelter costs have risen. People still eligible for Medicaid find that Medicaid covers fewer services, for fewer days, from a shrinking pool of physicians willing to see Medicaid patients at all. People on food stamps now get an average benefit that works out to just 47¢ per person per meal (70¢ if the family has absolutely no income). Pregnant women in the WIC program now get fewer ounces of milk in many states; children in the Child Care Food Program now get fewer meals; static welfare benefits have been badly eroded by rising prices. Those who still get help, get less.

Moreover, the continuing high rates of unemployment are at the same time a cause of rising need and an important reason why state and local governments do not have revenues available to make up for the loss of federal funds. So, at a time when more than 44 million people are living on incomes so low that they might be expected to seek help from public sources, federally-funded help has been sharply curtailed, and state and local revenue sources are too badly strained to make up the difference.

It should come as no surprise that soup kitchens, emergency food outlets, crisis centers and shelters for the homeless are among the nation's few remaining "growth industries" this year. At the beginning of the month they serve the millions who are in economic crisis but who get no help from government sources; by the end of the month they are also serving those who get help that is known to be inadequate, benefits that are designed to run out by the end of every month.

Information.

With clinics, hospitals, social agencies, and welfare departments simultaneously experiencing reductions in staff and increases in caseloads that make reduced levels of care inevitable, staff in those same agencies are not spending their time collecting data on changes in their clients, in the help they receive, or how the budget cuts affect them. Since the relevant federal agencies have also cut back on data collection and support for less research, too little systematic data collection is underway to assess the impact of the major changes occurring in health and social welfare systems during the past few years.

So, although one might guess that circumstances like those already described would have consequences for people in need of public services, it is not easy to get information on just what those consequences are in as careful a fashion as all of us might like. Reliable information has always been an essential tool of the public policy process; it is ironic that we should have so little good information available now when budget constraints make it doubly important that public resources be carefully allocated.

Decision-makers will not even have basic information available to them that would help them target services most effectively. Every odd-numbered year since the 1960's, for example, there has been an in-depth look at families using Aid to Families with Dependent Children: the AFDC Characteristics Study. At regular intervals, that series of reports has provided a consistent set of information on low-income families who depend on welfare and Medicaid. It was issued last in March of 1982, based on data collected in March of 1979. No data was collected for the Characteristics Study in March of 1981 or 1983. Now, when major policy changes may be expected to have a profound impact on low-income families eligible for AFDC, that series has been cancelled.

We will learn something from the studies being carried out with private funding by the Universities of Michigan and Chicago, and by Columbia and Princeton

Universities. Their sampling of families cut from the AFDC program might have usefully been compared with the Characteristics Study -- but of course that is no longer possible.

Nor will it be possible for health and social service providers to redirect services and programs to areas with the highest concentrations of low-income people. In the past, there was a regularly scheduled "mid-term" census which drew from a large enough sample at five-year intervals to help local planners make adjustments in service plans between the big Decennial Censuses. But that mid-term census has been cancelled for 1985.

The 1980 Decennial Census is now to be the only source of county-by-county poverty data (with refinements by age and race and sex) until 1983. Those who wish to locate child health or welfare services where there are large numbers of low-income families with children will have to rely on ever more outdated information.

Other surveys and data sources have been cancelled or delayed, and not always for reasons of budget. There will be no data collected through HANES (the Health And Nutrition Evaluation Survey) in the 1980's that will be available in the 1980's. Anyone hoping to use information from that particular source will find it so delayed as to be meanful only as a tool for long-range or comparative policy. Other data that is still routinely collected is less likely to be promptly analyzed or published than in the past, and special studies of national relevance are increasingly rare.

As a result, anecdotal evidence, case studies, and even very small surveys undertaken by students and non-professional advocates have become a major source of information (in some cases the only source of information) for elected officials and other policy-makers at state and local levels. Such efforts will take on growing importance as policy-making tools, as time elapses and the remaining federal data sources become more inappropriate. Major policy changes will be made on the basis of information that cannot possibly be consistent from state to state or county to county, and which will inevitably be subject to attack for inconsistency

and lack of sophistication. That will now be a given in virtually every area of public policy affecting children and other vulnerable people: health, nutrition, income security, social services, services for the mentally and physically disabled.

That should be of grave concern for more reason than one. We have seen the damage that can result when the President uses inaccurate anecdotes to justify bad policies. But apart from his stories, the anecdotal evidence has a terrible, almost entirely negative consistency -- and there is no large-scale, more objective information against which it may be measured.

Given the nature of the evidence, and the lack of anything else, I am particularly concerned that we treat the information becoming available as a kind of "early warning system." It would appear that something is going very badly wrong by most of the accepted health and social welfare indices. Right now, before any more damage occurs, we need to do a systematic job of compiling the observations of experienced health and welfare professionals across the nation, and put in place a careful, deliberate examination of such information as can be had.

Ultimately, everything already mentioned -- the budget cuts, their impact on programs, the context in which the decisions are being made, the dangers inherent in losing basic data sources -- is important only because of the consequences for people in need of assistance. Unfortunately that story is if anything, even worse.

Impact on People

In my travels I have become a kind of moveable survey, making my way through over thirty states since just before the budget cuts began to take effect (seventeen states since January). As I learn something in one state, I pose the issue as a question in every other state I visit. In that way I have been recording the impact of reductions in basic services through conversations, direct observation, and news reports collected from all over the country. These observations are weighed against my own experiences over the years as staff of the U.S. Senate Select Committee on Nutrition and Human Needs, as a researcher and writer, and as an

official of the Department of Health, Education and Welfare. What I am seeing and learning now troubles me not just because it adds up to such a discouraging picture, but because I find that I am hearing and seeing things that I have not seen or heard for ten or fifteen years, watching tragedies develop that are entirely avoidable by public policy devices that are known and proven to be effective.

As long ago as 1981, I began encountering the affects of the recession -- questions about how to set up soup kitchens and whether there were any programs for the long-term unemployed. That gradually gave way to comments first about the growing numbers in need of emergency food, and then to observations on the changing makeup of those seeking emergency aid. Once it was unusual to see whole families, or life-long workers in soup kitchens. Now it is common. Everywhere I go I am told that on "non-school days" the soup kitchens fill up with children (a problem compounded by the coming of summer holidays and a 1981 budget cut that made many private, non-profit summer lunch programs -- like those run by priests and nuns -- ineligible for federal funds). Some time in 1982, I began to pick up comments from nurses and social workers, from hospital emergency room and WIC program personnel, that they were seeing more of almost everything that one would hope to see less of.

I first learned about the problems of inadequate medicaid coverage and of basic pre-natal care for low-income women from nurses in North Carolina. I then raised the question in other places I visited, and learned that it is a problem everywhere. We first heard of increased numbers of malnourished children from pediatricians in Boston and then, by the same route, began to accumulate similar accounts from pediatricians, pediatric nurses, and WIC nutritionists in many other cities. I first learned that more children were being offered for temporary placement in foster care by their parents from Oklahoma, and have since been told that it had become more common -- particularly when the weather started to turn cold last fall -- in Massachusetts, Mississippi, New York, and the District of Columbia. The details differ from place to place, but the basic descriptions have a terrible, troubling sameness from big towns and small, rural

and urban areas, in state after state.

I mention my "findings" in speeches at conferences and universities, and more often than not, someone from the audience says, "I'm a doctor/nurse/nutritionist/ social worker, and I see what you're describing in my practice every day." Or someone will call me several days later to say that they had asked at their local clinic, only to find that the problems I'd described were present in their community, among their neighbors, as well.

What follows then are some of the findings from this personal survey, observations of conditions that I now accept as commonplace (and which are also being reflected in the monitoring efforts undertaken by local advocacy organizations) because I have heard them in some form so often in my travels.

Survey Results.

-- First from Oklahoma, then from staff of the Child Welfare League of America and the Family Services Association, finally from child advocates in cities and states across the nation, came reports of an increase in families asking social agencies to place their children temporarily in foster homes.

The first account came from the director of a children's home in an area full of unemployed people from the Midwest. He explained that these families often exhausted any savings before taking to the road, and then when they could not find work were living with their children in abandoned buildings, in State Parks, or in their cars. Not eligible for welfare in any of the 29 states that give no aid to families in which a father is present, they might be eligible only for food stamps. With no way to shelter their families (or even to make the food stamps last past the third week of the month), and unfamiliar with more traditional social agencies, they would turn up at Travellers' Aid desks in the Bus and railroad stations, seeking a way to find help for their children.

This was more common as cold weather began to settle in and families needed a warm safe place for the children. Interestingly enough, it was not just States

that won't give aid to families with two parents that report this new phenomenon; States that cover two-parent families but then provide too little for even basic subsistence create the problem as well.

-- Nurses and social workers in central Florida told of seeing more very young mothers having children they did not want after being denied family planning services they could not afford. They go through troubled pregnancies without prenatal care, followed by difficult deliveries of tiny, underweight infants (who go immediately into Neonatal Intensive Care Units). When the hospitals call the mother two months later to say that now the baby can go home, but may be sickly or need special care, the mother may tell the hospital to find their baby a home.

-- Hospital personnel across the country report an increase in the number of women "presenting in labor" having had little or no prenatal care. The numbers vary widely when numbers are available, but they range from a 35% increase in one Philadelphia hospital to a temporary 100% increase in Los Angeles County (that now appears to be leveling off). One anaesthesiologist from Southwest Texas commented that he routinely sees such women in his practice, because they are so much more likely to have Caesarian sections, complicated deliveries, and low birthweight infants. I asked one hospital administrator who had figures comparing the last six months of 1982 with a comparable six month period in 1981 how he happened to have the figures in hand. Easy, he said, "it was such a common topic of conversation in the staff rooms that it occurred to me to check the numbers."

-- Recently I have been told of women who arrive at a hospital in advanced labor only to be turned away -- without care -- if they have no cash "up front" to pay the full costs of delivery. Stories are being told of women being shunted from one hospital to another in hard labor, sometimes to deliver their infants in the parking lots of hospitals that won't admit them without cash or Medicaid.

-- Personnel in hospitals and the vital statistics sections of some public health departments routinely comment on the increase in low birthweight infants being

born. Like the increase in women presenting in labor, it is common talk in some hospital staff rooms these days. At Metro General Hospital in Cleveland, for example, 619 low birth weight babies were born in 1982, up 109 from 1981; requests for emergency infant formula for inadequately nourished infants went up 162% for December, 1982 compared with December, 1980.

The costs associated with supporting very low birth weight infants through the first weeks of life are commonly reported as \$1,000 or more per day, or roughly \$50,000 - \$60,000 for the infants that don't survive. Bills of \$100,000 or more are common for those tiny infants that do survive. And, if those infants have permanently disabling conditions, are seriously retarded or handicapped, lifetime institutionalization costs run about \$2 million in two states where we've inquired. -- In January of 1983, having learned that the relevant federal agencies had done nothing to follow up reports of disturbing increases in infant mortality rates in Michigan, and concerned that Congress was about to enter another round of budget cuts for even basic maternal and child health and nutrition services, we did a quick telephone survey of infant mortality rates in 37 states. We heard repeatedly of increases in neonatal mortality rates, in congenital malformations as a cause of death, and of little prenatal care for the mothers. Many commented on the difficulties faced by families who had lost their health care coverage when they lost their jobs.

With appalling regularity we learned of death rates for minority infants that are two and three times those for white babies, and of rates in some parts of the country like those to be found in Central America or Africa. Wide disparities exist from state to state, within states, and between racial groups, disparities that should cause major, dramatic public policy shifts; few are in evidence.

This summer as we repeat our survey to incorporate Final 1982 statistics with the four years' previous, we have chosen to use a written instrument and to include information on neonatal mortality rates as well as incidence of low birthweight

and (where available) disaggregations by race, teenage pregnancies, and point at which the mother began receiving care. We have assembled an advisory committee drawn from state and local maternal and child health programs, academia, the American Academy of Pediatrics, the American College of Obstetrics and Gynecology, the American Public Health Association, the American Nurses Association, and a former Director of the National Center for Health Statistics. It is curious that this activity should have to be carried out by an advocacy organization rather than by responsible federal agencies.

-- Pediatric nurses and pediatricians in major city hospitals are reporting that they are seeing more "failure-to-thrive" children admitted for care. In Los Angeles, Chicago, New York, New England and elsewhere, hospital personnel and Failure to Thrive Teams are beginning to track the number of failure-to-thrive children because of staff observations that this is a growing problem. A variety of research approaches is being employed in each hospital, but the impetus in every case is the same.

A pediatric nurse working in wealthy Long Island, New York mentioned that they are now seeing infants aged 3-4 months back in the hospital weighing less than they did at birth -- an observation reiterated by emergency room staff in Chicago.

-- Of 400 children coming to Boston City Hospital in recent months, a study by the Harvard School of Public Health found three times the number expected with heights and weights below the fifth percentile; a Kansas City, Missouri hospital nutritionist reports 13 percent of inner-city school children in a recent sample survey had abnormally low weight gains. School nurses generally are reporting more days lost from school due to illness, more colds, more flus.

-- Reports of cases of water intoxication are up. I have been told of cases in Cleveland, Dallas, Chicago, New York, Milwaukee, and Rockford (Illinois). At Cook County General, in Chicago, pediatricians normally see one case a year (an occasional, aberrant case of severe abuse or neglect is not unlikely in big cities) but in 1982 there were five cases. These were attributed not to abuse or neglect,

but because "families don't have the money for formula." A nutritionist in West Dallas was quoted as saying that almost daily she treats children who are sick because their infant formula has been diluted to make it last longer, and a nearby hospital is seeing many children who are sick from malnutrition, who "...have little or no subcutaneous fat, or sometimes they are vomiting."

-- Volunteers in soup kitchens, emergency food "pantries" and even public health clinics provide a kind of corroborating evidence of the problem: they commonly tell of mothers who come seeking not food for themselves, but just milk for the baby's bottle, or formula -- because there is nothing for the baby at home. Health clinic workers in one Southern state told of "stockpiling" infant formula in their clinic's closets, as are nuns at Marillac House on Chicago's West Side.

-- Professional nutritionists are sufficiently concerned about anecdotal evidence of disturbing trends that they are working to increase nutrition surveillance and the collection of hard evidence in a form that will be useful to state and local policy makers. Efforts are already underway in five states (Illinois, California, Minnesota, Massachusetts and New York) to collect systematic information on large segments of the population.

-- Two nurses working with the long-term unemployed in Detroit report that they now routinely question adults on their diet (including how often they eat solid food) and have recorded low potassium levels and other clinical evidence of poor nutrition among adults. They are seeing conditions stemming from long-term poor nutrition that they last encountered in their nursing school textbooks.

-- "Nutrition Watch," a Commission appointed by former New York Governor Hugh Carey, met for six months of testimony and evidence from a broad range of witnesses and professional perspectives. They concluded that "hunger...is again on the rise in New York State." The Commission noted evidence that an estimated 20% of those hospitalized in New York State had nutrition-related illnesses.

-- Hospital dietitians report that they are being asked for more "Emergency Room

Trays." People who are found unconscious, or vomiting in the streets, are brought to hospital Emergency Rooms where the cause must quickly be established (e.g. diabetic shock, concussion, alcoholism...). When someone has just not had solid food for some days (a condition well documented by the East Harlem (NY) Interfaith Welfare Committee), then the Emergency Room will ask the dietitians for food. The patient is treated with an "emergency room tray:" first a light meal (and a place to lie down briefly), then a second meal, and released.

-- One anecdote that is commonly told, in every region of the country, concerns popcorn. Poor mothers buy popcorn early in the month, and then when the food stamps run out they give the children "popcorn and a lot of water" --for at least a feeling of full stomachs; hungry babies get "sugar water" when there is no money for food. They know it isn't good for the children, but without money, they have no choice.

-- Professionals working with the elderly report an increase in health conditions related to prolonged poor nutrition. Corroborating evidence comes from staff in senior citizen nutrition programs who report an increased need to send participants home with "care packages" on the weekends, (especially near the end of the month) and emergency food providers who report an increase in seniors seeking emergency food.

EVIDENCE.

There may not be nationally consistent, sophisticated data in hand to document just how and to what degree low income children and their families are being affected by the budget cuts and policy changes of recent times, but that does not mean we have no idea what is happening, or that we cannot draw any conclusions from the information that is available.

In the area of food and nutrition, for example, I know the answer, and I suspect it is not much different in most other areas of public policy important to children and their families. There are six kinds of evidence available now, evidence that hunger and malnutrition are serious problems once again -- at least in part because of budget and policy choices.

(1) The numbers. The increase in poverty that has been recorded since 1979 serves a useful purpose for this discussion because the poverty count represents a good surrogate for a "hunger count." By definition, people below the poverty line have less than the income needed to purchase a minimally adequate, temporary diet "for emergency use when funds are low." That is not to say that they are hungry or malnourished every day, or that all of the poor show evidence of malnutrition, but the poverty count does provide a good sense of the scale of the problem, the size of the group at risk.

In 1981 there were 32 million people living below the poverty line and another 12 million with incomes just above the poverty line. That means that about one in five Americans was living in a low-income household. That represents a higher incidence of poverty than there has been in this country since 1967.

And if poverty is up, by definition, the population at risk of hunger is up.

(2) Private agencies. Emergency food outlets represent a kind of "early warning signal" that something is going badly wrong. The fact that there are now, in towns and cities across the country, soup kitchens and emergency food pantries serving numbers that grow daily and populations that now increasingly include children, should send off alarm bells. That fact alone should prompt a careful look at policies and programs that leave such so much emergency need unmet, that have resulted in soup kitchens and emergency food outlets even in such unlikely areas as the rich Nappa Valley (California) and wealthy Long Island counties (New York).

(3) Public agencies. In June the U.S. Conference of Mayors declared hunger to be the most insidious and fastest growing problem facing city agencies everywhere. In a survey of Mayors last fall, 73% of those responding said that requests for emergency food and emergency shelter topped the list of requests for help from city agencies.

Other public programs also provide evidence of increased need. The special supplemental food program for Women, Infants and Children (known as WIC) reports long waiting lists in many parts of the country, while food stamp and welfare offices nationwide report an increase in applications; social agencies of all kinds now talk of turning people away as need exceeds ability to help.

(4) Media reports. As anecdotal reports of hunger or homelessness or personal tragedy surface, journalists are sent out to cover the local story, to see whether something is true in their own backyard. In city after city, month after month, seasoned journalists have gone out to investigate and have come back to their news organizations with variations on the same basic theme: hunger and malnutrition are real and growing problems all across the country once again. Television documentaries, radio programs, news broadcasts, Sunday Supplements, daily papers, specialty press, and popular magazines have all assigned reporters to investigate the issue and then run stories citing evidence that hunger is a serious problem once again.

(5) Local Studies. We may not have federal studies, but there is a growing "bibliography" of smaller, local studies: from university, church, advocacy, and community groups, in Oklahoma, Northern California, West Virginia, New York, Rhode Island, Chicago....have come local studies showing that hunger and malnutrition are present and growing once again.

(6) Medical evidence. It is one thing to note that certain services or benefits have been curtailed, and quite another thing to be able to point to clinical evidence that the health and well-being of children is being compromised. Showing cause-and-effect relationships is difficult if not impossible for any one specific benefit or service. But if more children are failing to grow and develop normally under circumstances which show more families unable to feed their children, then the time has come for a careful reconsideration of the policies and the evidence. And the medical evidence, as sketched out earlier, is beginning to come in.

PUBLIC POLICIES -- FIVE BRIEF POINTS

It is worth taking note when those in public life adopt policies that undermine our public health, nutrition, and social welfare systems just when the need for publicly-supported benefits and services is known to be rising so steeply. Both the policies and the policy-makers deserve more attention than I can give them here. But I want to make some broad observations about apparent shifts in public policy that have taken place, with important long-term implications.

(1) There has been a shift to non-cash forms of assistance.

Over the years, in-kind assistance was justified only under certain limited circumstances: when the recipients of help were unable to manage money for themselves (the profoundly retarded, emotionally disturbed, very young or very senile); when the good or service could not be provided at reasonable cost through the private sector without in-kind assistance in the form of subsidies (affordable, low-cost housing is an example); or when the good or service required could not reasonably be purchased on an individual basis (families cannot "purchase" teachers and construct separate schools for each child, so public education is provided).

It has long been understood that what mentally competent people in economic crisis need is cash. That way they can make their own decisions about meeting the needs of their families through the private market just like everybody else. Cash aid is one means of fostering a return to independence, to reliance on personal choices, and to preserving some semblance of dignity for people in crisis.

But in recent years there has been an escalating shift to in-kind benefits rather than cash: to paying the landlord, the utility provider, the doctor; providing food stamps and other forms of vouchers with strictly limited use. To the degree that the politicians are willing to help people in crisis, they are willing to do so by putting money in the hands of the vendors of essential services and benefits and not by putting money in the hands of poor families.

Nonetheless, although low income people are currently far less likely to have cash from either jobs or welfare, fees are now being required for many essential services. So the shift to in-kind forms of assistance has taken on a perverse quality: at the very time that people are less likely to have money and be more in need of basic services, they are more likely to have to pay... for preventive and primary health care, family planning, child care, mental health, and a host of social welfare services.

- (2) There is an implied rejection of knowledge and experience in recent public policy decisions.

The past two years might lead one to question whether federal and state legislators had made a conscious decision to reject knowledge and experience as a basis for their decisions. If knowledge and experience were being used as guides, very different policies might be adopted. For example....

The strong association between poverty and ill-health is well known and well documented. With higher rates of poverty come higher rates of almost everything that health and social welfare professionals work to minimize. There is a solid knowledge base that tells us to expect higher rates of disease, of infant mortality, of stress-related physical and mental illnesses, of deaths, of generally poor health conditions. This is true whether it is measured among poor populations, in poor areas, and/or during periods of economic instability.

So, knowing what we know about poverty and ill-health, and about the striking increase in poverty in recent years (known to Administration policy makers before they drafted their FY 1984 budget proposals, and known to Congress as they consider those proposals) one might logically have expected some or all of the following:

- an expansion in basic health and nutrition services known to keep the incidence of low birthweight (and by implication infant mortality rates) down;
- a data collection system focused on "impact" data in order to track the health and social implications of prolonged recession and rising poverty -- much the way changes in the economy are already tracked;

- increased data collection targeted on particular high-risk groups and geographical areas most likely to suffer the consequences of a poor economy;
- a system of supports for the poor and unemployed which acknowledges the reduced availability of cash income through:
 - ° reduced reliance on co-payments, fees, and charges for basic services;
 - ° expansion of reimbursement mechanisms when people have less cash;
 - ° strengthened public health, education, and social welfare systems whose services will be in greater demand.

Any of the steps listed above would be part of efforts to minimize the adverse health and social consequences of persistent unemployment and rising poverty, yet none has been put in place. Budget proposals calling for additional cuts in Medicaid, the Preventive Health Block Grant, services for the Developmentally Disabled, child nutrition, food stamps, foster care, and AFDC (among others) run exactly counter to what might be expected from policy makers desirous of doing the most to help vulnerable children and their families through hard times.

(3) Policies are enacted as though they have no consequences.

It is a closely related point, but much of the adverse effect of recent policy changes was predictable. Reducing basic services at a time when need is growing and no alternative sources of service or care exist, implies a policy choice to which few people would openly admit. Reductions in basic services can be expected to maximize the adverse consequences of long-term unemployment and poverty, though surely no one in public life would cite that as a rationale for national policy.

Similarly, disparities between White, Black, and Hispanic, in terms of poverty incidence, health status, educational opportunity, and access to basic services have been mitigated by public programs. If we cut those public programs and put nothing in their place, we can predict that the disparities between economic and racial groups will be exacerbated; that follows automatically. Whether taking those steps is racist in-intent is debatable; that those policy choices are racist in their consequences is unavoidable.

If we know that early and regular pre-natal care and sound nutrition keep down

the incidence of low birthweight and with it infant mortality, and we cut those services, we can predict that more babies will be born underweight, vulnerable and more likely to die in infancy. Of those that survive, more are likely to be physically or mentally disabled. And we can also predict that more of those adversely affected infants are likely to be the children of poor and minority families. It may not be the intent of Congress and the President to insure more retardation, more disability, more infant deaths, but that is the consequence -- known and entirely predictable.

Professionals, thoughtful citizens, and policy makers know the consequences of failing to insure some level of essential services. Each vote in favor of more reductions in (or against reasonable levels of) basic assistance has consequences.

(4) We are developing a system of Three-Class Care.

It used to be common to worry about moving toward a system of two-class care in which different levels of service or care would be provided, in separate settings, depending upon ability to pay. Today that is already common. Restrictions on eligibility for basic health and other publicly-supported services is in fact creating a "system" of Three-Class Care.

There are First Class services, in private settings and facilities, for those with private insurance or the ability to pay. First Class care includes high-technology medical care, specialized education, sophisticated therapy, private governesses/tutors....

Second Class care for the most part involves limitations on coverage and services, tends to be provided only in a limited number of settings (usually public), and entire categories of services may not be provided at all. Second Class care is available to those still able to qualify for Medicaid, welfare, or other means-tested social programs.

Third Class care is a creature of public policy choices in the 1980's. It represents no care at all. It is for those too poor to afford services or help

through private means, but not eligible for publicly-supported services or care.

Third Class care is the only option for the families in which a father is present but where welfare and medicaid are limited to single-parent families, for the "new poor" who simply do not fit the eligibility rules governing public programs, and all of those who are still technically eligible for services or care but whose eligibility is meaningless because the services no longer exist. They are the people who live near the agencies that are turning people away, the families with disabled children whose school systems no longer make education for such children available, the people living near health clinics that have closed or doctors who no longer see Medicaid patients, the pregnant women who come to a WIC program that has no more room except on a waiting list . Being eligible for services means nothing in these circumstances if, eligible or not, the services or care are not to be had.

- (5) Recent budget choices reflect a willingness to tolerate consequences for others that we would not tolerate for ourselves, and should not tolerate for anyone in a country as rich as ours.

As discouraging as the last few years have been, the present period may yet emerge as the worst. It was one thing to have some sense of what might happen, and to watch the President and Congress make what appeared to be wrong choices. Initially at least it was possible to give everyone the benefit of the doubt.

But it is quite another matter to have evidence that those policies are causing real and growing harm, only to see the evidence denied on highly questionable grounds. After insisting that the people in the soup kitchens and emergency food lines were not really needy, one Agriculture Department official was asked whether he'd ever actually been in a soup kitchen. No, he acknowledged, but he'd seen one on t.v. An aide to Jesse Helms justified more food program reductions because:

There is absolutely no hard evidence that there have been increases in malnutrition or in infant mortality rates as a result of the Reagan administration changes in federal nutrition programs.

Technically of course, he is correct. That is in part because most of the data

sources that could provide "hard evidence" have been delayed or cancelled. But even with good data collection it would be difficult to prove in an absolute, cause-and-effect manner that a particular health condition was caused directly and solely by a change in a particular policy. People are not laboratory animals whose conditions can be strictly controlled and measured, who can be deprived of basic nutrients or medical interventions and compared with control groups who were.

But if action is to come only AFTER that clinically perfect, unchallengeable scientific evidence is in hand, many more lives will be compromised in the interim. Few would want their children's lives to depend on such rigid standards; it should not be tolerated on behalf of others' whose lives have been put in crisis by a faltering economy.

Right now, for people living in recession-hit homes and neighborhoods across the nation, there is a high and rising sense of anxiety, a terrible feeling of having been "written off" by everyone with a voice and the power to speak out. It is hard for any American to believe that others could know of their hunger, their pain, their inability to get a doctor for a sick child or for a woman in labor, and look the other way.

And now in my travels I find them joined by the people who work in soup kitchens and emergency food programs, in the hospitals and clinics, in poor neighborhoods everywhere. There is the anger of decent people who are made to do the dirty work for the politicians. They, not David Stockman or the Congress, have to tell the anxious parents that the food has just run out, that there will be no care, no help, for their wife, their child, their family. Helping and helped alike, they want to know whether anybody is listening, whether anybody cares.

Years ago, in a crowded U.S. Senate hearing room six nationally-prominent pediatricians testified that they had seen children starving in America. They were followed by witnesses who accused them of having made slanderous charges, of being outsiders with no right to speak.

When some of the heat and emotion had died down, Senator Joseph Clark of Pennsylvania turned back to the doctors, and asked if any of them would like to comment. Answering for the group was the late Dr. Raymond Wheeler of North Carolina, who said in part:

I reported what I saw because it seemed to me intolerable that this situation should exist in the region which I love.

I saw these children and their parents and I told you what I saw and the message of despair and helplessness which they communicated to me.

The time has come when this must cease, for we are now concerned with little children whose one chance for a healthy, productive, dignified existence is at stake.

I invite the Senators...to come with me ... and I will show them the children of whom we have spoken. I will show them their bright eyes and innocent faces, their shriveled arms and swollen bellies, their sickness and pain and the misery of their parents.

Their story must be believed, not only for their sakes, but for the sake of all America.

(U.S. Senate Hearings, July 11 and 12, 1967.)

It is time to heed the doctor's message once again.